

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Moniteau  
Township Pleak Grove  
or  
Village  
or  
City

Registration District No. 577 File No. 8  
Primary Registration District No. 5775 Registered No. 13452-13  
(NO. 2) St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Mary Elizabeth Crutchfield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX.. <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE MARRIED WIDOWED OF, DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>Oct 9 1847</u> (Month) (Day) (Year)		
7 AGE <u>72</u> yrs. <u>5</u> mos. <u>9</u> ds.	If LESS than 1 day.....hrs. or.....min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Moniteau Co.</u>		
PARENTS	10 NAME OF FATHER <u>William Francis</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Do not know</u>	
	12 MAIDEN NAME OF MOTHER <u>Mary James</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Do not know</u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 1 1919 to March 15 1920, that I last saw h. alive on March 15 1920 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH\* was as follows:  
Coronary Arteriosclerosis of Heart

(Duration) 2 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) M

(Signed) J. R. Roberts M. D. Mar 17 1920 (Address) Luttwig St

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds.

Where was disease contracted if not at place of death?  
Former or usual residence.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Paul Williams  
(Address) Evansville Mo

15 Filed..... 191.....  
Registrar

19 PLACE OF BURIAL OR REMOVAL Union DATE OF BURIAL Mar 17 1920  
20 UNDERTAKER ✓ ADDRESS

RECORD

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

WHITE PLAINLY WITH UNFADING INK

M. B. B.—Brevium of Informa  
CAUSE OF DEATH in plain

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified; is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

**1. PLACE OF DEATH**

County Monticou  
Township West Gran  
City Monticou (No.       )

Registration District No. 577  
Primary Registration District No. 5775

File No.         
Registered No. 8  
St.        Ward       

**2. FULL NAME**

(a) Residence. No.        St.        Ward         
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF       

6. DATE OF BIRTH (MONTH, DAY AND YEAR)       

7. AGE YEARS MONTHS DAYS If LESS than 1 day,        hrs. or        min.

**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work         
(b) General nature of industry, business, or establishment in which employed (or employer)         
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)         
(STATE OR COUNTRY)

10. NAME OF FATHER       

11. BIRTHPLACE OF FATHER (CITY OR TOWN)         
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER       

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)         
(STATE OR COUNTRY)

14.

INFORMANT         
(Address)       

FILED Mar 18 20 R. L. Latham REGISTER

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 17 19 20

17. I HEREBY CERTIFY, That I attended deceased from       , 19       , to       , 19       , (that I last saw        live on       , 19       , and that death occurred on the date stated above, at       .)

THE CAUSE OF DEATH\* WAS AS FOLLOWS:       

CONTRIBUTORY (SECONDARY)         
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED         
IF NOT AT PLACE OF DEATH       

DID AN OPERATION PRECEDE DEATH?        DATE OF       

WAS THERE AN AUTOPSY?       

WHAT TEST CONFIRMED DIAGNOSIS?       

(Signed)       , M. D.  
, 19        (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL       

DATE OF BURIAL       

20. UNDERTAKER       

ADDRESS       

Dischultz California

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which gives any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.